



355 Montevue Lane Frederick, Maryland 21702 • Phone: 301-600-1582 • Fax: 301-600-2821

APPLICATION FOR ADMISSION

1. PERSONAL INFORMATION

Name: _____ Sex: F _____ M _____

Address: _____

Previous Address If less than 5 years: _____ Rent: ____ Own: ____

Phone: _____ Cell Phone: _____ E-mail Address: _____

Date of Birth: ____ - ____ - ____ Place of Birth: _____ U.S. Citizen: Yes ____ No ____

Social Security Number: ____ - ____ - ____ Marital Status: Single ____ Married ____ Divorced ____ Widow ____

Maiden Name: _____ Spouse's Name: _____

Veteran: Yes ____ No ____ Branch of Service: _____ Years Served: _____

Spouse a Veteran: Yes ____ No ____ Branch of Service: _____ Years Served: _____

Applicant's Current Location (if different from above) _____

2. MEDICAL INFORMATION

Attending Physician: _____ Phone : _____

Address: _____

Will this physician be responsible for your care while at Montevue Assisted Living? Yes _____ No _____

Last dates for hospitalization or Skilled Nursing Facility (SNF) and name of facility: _____

3. PERSONAL CONTACT

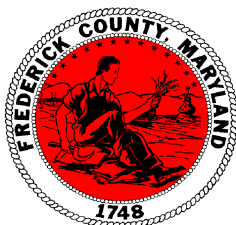
Power of Attorney or Responsible Party (Upon admission, a current copy of Attorney designation is required)

Name: _____ Relationship : _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____



4. EMERGENCY CONTACTS:

Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail Address: _____

Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail Address: _____

Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail Address: _____

5. HEALTH INSURANCE

Primary Carrier: _____ Policy #: _____ Group # _____

Secondary Carrier: _____ Policy #: _____ Group # _____

Medicare Part A #:	_____	Effective Date:	_____
Medicare Part B #:	_____	Effective Date:	_____
Medicare Part D #	_____	Effective Date:	_____
Medical Assistance #	_____	Effective Date:	_____

Do you receive VA Health Benefits? Yes _____ No _____ If so, please provide Service Number/SSN _____

6. PERSONAL ARRANGEMENTS

Name of funeral home to be contacted in case of death: _____
Address: _____ Phone: _____
Burial Arrangements: Pre-paid? Yes _____ No _____ Date pre-paid: _____ Irrevocable? Yes _____ No _____
Desired type of burial: _____
Name of Cemetery: _____
Address: _____ Phone: _____

7. FINANCIAL INFORMATION (*All information is confidential. List only applicant resources*)

Applicant's monthly income	\$ _____
Social Security	\$ _____
Retirement Pension (source and amount)	\$ _____ from _____
Equities	\$ _____
Interest/ Dividends Income	\$ _____
TOTAL	\$ _____

FINANCIAL INFORMATION CONTINUED**Bank Accounts**

Name of Bank(s)	Type of Account (Checking, Saving, or If other please list)	Current Balances
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Stocks and Bonds

Name of Corporation	Owner	# of Bonds or shares of stock	Value
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Life Insurance Policies

Company Name	Policy Number	Owner	Beneficiary	Cash Value
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Annuities/ Trusts

Beneficiary	Monthly Income	Value
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Please provide copies of last three years tax returns

Tax Year	Gross Income
_____	\$ _____
_____	\$ _____
_____	\$ _____

8. Real Estate (if owned individually, joint names, or as tenants in common, so indicate)

#1 Address _____
Manner of ownership: Individual ____ Joint ____ Name of joint owner _____ Other ____
Value of Property \$ _____ Date Appraised: _____

2 Address _____
Manner of ownership: Individual ____ Joint ____ Name of joint owner _____ Other ____
Value of Property \$ _____ Date Appraised: _____

I have completed this application to the best of my knowledge and understand that falsification of this application will be grounds for immediate discharge, if such is determined. If admitted to Montevue Assisted Living, I agree to abide by the facility and regulators, policies and procedures and/or regulations. I fully understand that I may be discharged from Montevue Assisted Living if in the opinion of the Administrator such action is deemed appropriate. It is further understood and agreed that if unable to pay, Frederick County may make a claim on the estate (Property, Insurance, etc) of the resident to defray expenses and request payment should the resident becomes financially able through improved personal resources.

9. SIGNATURES

Resident: _____ Date: _____

POA/Responsible Party: _____ Date: _____

Reviewed By: _____ Date: _____

Witness: _____ Date: _____

Reviewed By: _____ Date: _____

Applicant has been ____ Approved ____ Rejected for Admission

Administrator Signature: _____ Date: _____